

1 R01 Managed Care and Access to Alcohol Treatment Services
AA12085-01

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Funding Period: February 1998 - January 2001

BACKGROUND / RATIONALE:

Current evidence indicates that managed care has reduced the growth in health care expenditures without having adversely affected the majority of patient outcomes. However, it has been argued that any adverse effects of managed care are most likely to involve particular subgroups of the mentally ill. The Institute of Medicine's recommendations concerning managed behavioral health care research strongly emphasize the importance of examining issues of access for high-risk populations.

OBJECTIVE(S):

This study describes the physical and behavioral health benefits of a representative community-based sampled of rural and urban at-risk drinkers potentially in need of behavioral health services.

METHODS:

A screening instrument for at-risk drinking was administered by phone to approximately 12,000 residents of six southern United States and 442 at-risk drinkers completed four interviews over a two year period and consented to release insurance and medical records. Two thirds of the sample (n=294) were insured during the last six months of the study. Health plan characteristics were successfully collected for 217 (72.3%) of the insured at-risk drinkers. The health plan survey asked about type of health plan, outpatient mental health and substance abuse coverage, supply-side cost containment strategies (e.g., gatekeeping and provider choice restrictions), and demand-side cost containment strategies (e.g., deductibles, limits, coinsurance, and copayments) were also included on the survey. Analyses compared demand-side and supply-side cost containment strategies for physical health services versus behavioral health services and across rural and urban enrollees.

FINDINGS / RESULTS:

Provider choice restrictions were greater for behavioral health services than for physical health services ($p<0.0001$). Gatekeeping for behavioral health is utilized significantly more often than gatekeeping for physical health ($p<0.0001$). Increased cost-sharing for mental health compared to physical health was most often achieved using additional limits (82.9%) and higher coinsurance (65.6%) and less often achieved using higher copayments (37.5%) and additional deductibles (13.1%). Increased cost-sharing for substance abuse services compared to mental health services was not common among health plans. Rural enrollees were significantly ($p<0.001$) less likely to be enrolled in a health plan with gatekeeping policies. Compared to urban enrollees, rural enrollees are more likely to have to pay deductibles ($p=0.042$), more likely to have limits placed on physical health service use ($p=0.039$), more likely to have to pay coinsurance for physical health services ($p=0.001$) and less likely to have to pay copayments for physical health services ($p=0.036$).

STATUS:

Complete

IMPACT:

A majority of urban, but not rural community-based at-risk drinkers are enrolled in health plans employing managed care cost containment strategies. Compared to urban at-risk drinkers, rural at-risk drinkers appear to be enrolled in plans that rely more on demand-side cost-containment strategies and less on supply-side cost-containment strategies. Although most plans covered SA/MH services, cost containment strategies were greater for the SA/MH treatment than for PH treatment. These results provide benchmarking data for health plans and self-insured employers concerning the distribution of physical and behavioral health benefits across the insurance market. These results also provide relevant data to mental health advocacy groups and policy makers about how much equalization would have to occur in the health insurance market before physical health and behavioral health benefits will be the same for high risk populations.

PUBLICATIONS: None at this time.